Position: Healthcare Navigator (LMSW/LPN required; LCSW/RN preferred)
Location: New York NY
Reports to: Senior Healthcare Navigator
Hours: Full-time/40 hour per week, some evenings/weekends required

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About Jericho Project

Jericho Project is a nationally acclaimed nonprofit ending homelessness at its roots by enabling homeless individuals and families to attain quality housing, employment, and mental and physical health services. The 37-year-old nonprofit serves over 2,500 individuals, including 700 veterans, annually. Jericho has been a key partner in New York City's initiative to end veterans' homelessness, and is leading bold, innovative strategies to do the same for families and young adults.

Our programs touch four cornerstones of a person's life: housing, employment, wellness, and family stability. We create a culture of "moving on" through a foundation of housing and supportive services provided by expert program specialists and case managers.

We have over 550 units of supportive housing including 9 residences in the Bronx, Harlem, and Astoria, as well as scatter-site apartments throughout NYC.

About the Position

Jericho Project is seeking to recruit a full-time Healthcare Navigator, to develop and implement new health-care related services within the SSVF program. The Healthcare Navigator will provide services that include connecting Veterans to VA health care benefits or community health care services where Veterans are not eligible for VA care.

SSVF Healthcare Navigators will provide case management and care coordination, health education, interdisciplinary collaboration, coordination, and consultation, and administrative duties. They will work closely with the Veteran's primary care provider and members of the Veteran's assigned interdisciplinary treatment team. The Healthcare Navigator will work with a population of Veterans with complex needs who require assistance accessing health care services or adhering to health care plans.

Responsibilities:

- Provide case management and care coordination, health education, interdisciplinary collaboration, coordination, and consultation, and administrative duties.
- Collaborate closely with Assistant Director and 4 Case Managers to identify veterans in need of Healthcare navigation.
- Conducts assessments of the Veterans in collaboration with the interdisciplinary treatment team, the Veteran, family members, and significant others. The purpose of the assessment is to understand the Veteran's situation, potential barriers to care, the causes, and the impact of such barriers on the Veteran's ability to access and maintain health care services. The assessment

should highlight the Veteran's strengths, limitations, risk factors, and internal/external supports and service needs to optimize the Veteran's ability to access and maintain health care services.

- Regularly review care plan goals with the Veteran, conducts regular non-clinical barrier assessments, and provides resources and referrals needed to support adherence.
- Assist veterans in communicating their preferences in care and personal health-related goals to facilitate shared decision making of the Veteran's care.
- Monitor Veteran's progress, maintain comprehensive documentation, and provide information to treatment team members when appropriate.
- Evaluate the effectiveness of the resources and referrals provided and make appropriate modifications to ensure the provision of high-quality care and interventions.
- Connect Veterans to VA health care benefits or community health care services where Veterans are not eligible for VA care.
- Work closely with the Veteran's primary care provider and members of the Veteran's assigned interdisciplinary treatment team. Provide recommendations and identify concerns as needed.
- Work closely with the Veteran's assigned multidisciplinary team, including medical, nursing, and administrative specialists, and case management personnel. Direct activities to maximize effectiveness, efficiency, and continuity of care for Veterans.
- Act as a liaison between the SSVF grantee and the VA or community medical clinic.
- Work within interdisciplinary team to provide timely, appropriate, Veteran centered care equitably. The SSVF health care navigator works collaboratively with the team and the Veteran to identify and address systems challenges for enhanced care coordination as needed.
- Assist veterans access community services by conducting outreach and making needed referrals.
- Identify the Veteran and family's health education needs and provides education services and materials that match the health literacy level of the Veteran. Provide ongoing education support as needed. Identify resources to prevent disease and promote self-care. Refer Veterans and families to the appropriate interdisciplinary team member for identified health education needs when specialized health education is outside of the incumbent's scope of practice.
- Serve as a resource for education and support for Veterans and families and helps identify appropriate and credible resources and support tailored to the needs and desires of the Veteran.
- Act as a health coach by proactively supporting the Veteran to optimize treatment interventions and outcomes.
- Provide subject matter expert consultation to staff and community providers on the specialty area of practice.
- Consistently achieve sensitivity to all Veterans' individual needs concerning age, developmental requirements, and culturally related factors.
- Provide crisis intervention as needed
- Utilize electronic case management system. Maintain accurate and up-to-date client files.
- Participates effectively in SSVF team meetings, case conferences, supervision, and related activities
- Carry out other duties as assigned by Senior Healthcare Navigator or Program Director.

Requirements:

- Licensed Masters Social Worker (LMSW) or Licensed Practical Nurse (LPN) required. Licensed Clinical Social Worker (LCSW) or Registered Nurse (RN) preferred.
- At least two years of experience in a healthcare or social services area of practice.

- The health care navigator possesses excellent judgment, superior leadership, critical thinking, written, and verbal skills.
- Experience working in homelessness, substance abuse, mental health and/or trauma settings preferred.
- Strong computer skills as a lot of assignments are being completed virtually at this time.
- Knowledge of NYC resources preferred.
- Candidate must possess superior organizational, written and verbal skills.
- Self-starter with the skills and energy to work with high-need veterans in the community.
- Strong engagement and interpersonal skills.
- Experience working with veterans/military preferred.
- Ability to multi-task and find innovative ways to reach and effectively help others.
- Relentless dedication, high energy, and flexibility.
- Good interpersonal skills, working well with others and interacting effectively as a team.
- Proficient use of Microsoft Office Suite programs.

Compensation:
Salary is commensurate with experience. Jericho Project offers a comprehensive benefits package.

How to Apply:
Interested applicants must submit a resume and cover letter with salary requirements to:

Human Resources Department
Jericho Project
Job Code: **Healthcare Navigator**
245 W. 29th Street, Suite 902
New York, NY 10001
Fax 646.624.2301
careers@jerichoproject.org

No Phone Calls Please.

Jericho Project is an equal opportunity employer that does not discriminate in its hiring practices and, in order to build the strongest possible workforce, actively seeks a diverse applicant pool.
www.jerichoproject.org